Research Proposal for Ph.D on:

# Health Situation of Out-of-School Adolescent Girls: A Study of Particularly Vulnerable Tribal Groups (PVTGs) in Purulia, West Bengal

**Key words:** Health situation; Out-of-School; Adolescent girls; Particularly Vulnerable Tribal Group (PVTG); Purulia

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*Research Topic:*

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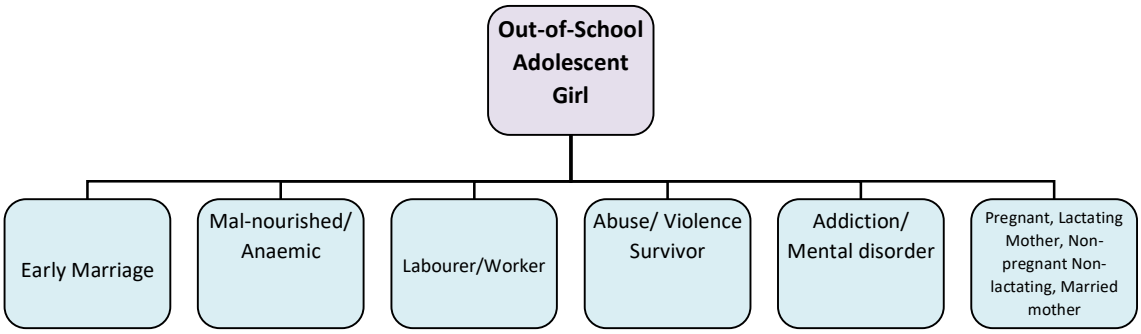
**Introduction:**

The percentage of youth and adolescents constitute more than one-fourth of the world's total population, i.e. the age group of 10 to 24 years (JE., 2004). By which it can be understood that the adolescent population is much higher than other the age groups. The population of adolescents as well as their proportionate share to the total population in India will be quite large over the next few decades. It is because of the high fertility rate in the eighties and the population momentum in the nineties and thereafter. As the adolescents represent the future of the country, their predicaments cannot be overlooked.

Globally, the age parameters of adolescents have been variously perceived and defined by different policies and programmes. In India, the recent draft Youth Policy defined the age group of 13–19 years as adolescents; whereas, the ICDS (Integrated Child Development Services) scheme have earmarked the age of adolescent girls as to be between 11–18 years but the Constitution of India and the labour laws have considered the individuals to be children who are within the age of 14 years. The Reproductive and Child Health (RCH) programmes in India consider 10 to 19 years of age as adolescent and this is also broadly followed by most of the UN agencies. The Planning Commission of India's report of the working group on adolescents for the Tenth Five-Year Plan (2001) also recommended the 10–19 years age group to define the adolescents. Since then, the policy makers have taken a slightly different view and defined 15–19 years of age as adolescents. Again, since the reproductive age has been defined to be within 15–44 years and the economically active age within 15–59 years, the statistically defined adolescents are both reproductive and economically active. The present proposed study therefore perceives 15–19 years of age ideally as adolescents.

As the children enter the adolescence phase, they bring along with resources and vulnerabilities (Blum RW, 2012). The vulnerabilities are often universal and the adolescents in the developed as well as developing countries face both health and social vulnerabilities. But situation-wise and geographically, some are more vulnerable than others (Fischhoff B, 1998). Likewise, the PVTG adolescents are more vulnerable than Non-PVTG adolescents and the Out-of-School adolescents are more vulnerable to health risks than School-going adolescents. According to UIS definitions, the out-of-school adolescents (OUSA) are those who are of the official lower secondary school age and in any case are not studying/ non-enrolled in primary or secondary education. The adolescents studying/ enrolled in pre-primary education or non-formal education are also considered as out-of-school adolescents (UIS, 2015a). The potentially vulnerable state of the adolescent girls who are out-of-school if further classified may be found as categorized below:




In 1973, the Ministry of Tribal Affairs set up 'Dhebar Commission' that named the Primitive Tribal Groups (PTGs) as a separate category among the tribes who are lesser developed among all the tribal groups. The PTGs were again renamed as Particularly Vulnerable Tribal Groups (PVTGs) in 2006. These certain tribes have been characterised on the basis of their greater 'vulnerability' (although the precise contours of their vulnerability has not been clearly defined) (Xaxa, May 2014). There are currently 75 PVTGs in India (3 in West Bengal) and has been identified on the basis of: i) Forest dependent livelihoods, ii) Pre-agricultural existence level, iii) Low rate of literacy, iv) Stagnant or declining rate of population, v) Subsistence based economy (or pre-subsistence level economy).

Adolescent's health is influenced by interactions between parents, peers and socio-economic environments. The experiences faced during early childhood development period and the protective and risk factors existing therein affect the health seeking behaviour patterns of the adolescents (Sawyer SM, 2012). Adolescents living in poor and unhealthy family environment increase the risks of academic problems, depression, suicidal thoughts, substance abuse and more sexual misconduct among them (Sodhi, 2012). Most of the young people are often presumed to be healthy but, as per the estimates of WHO, more than 2.6 million young people, aged between 10 to 24 years, die every year. Moreover, a much greater proportion of young people suffer from illnesses and 'behaviours' that usually hinders their ability to grow and develop to their fullest potential. It is found that around two-thirds of the pre-mature deaths and around one-third of the total disease burden appearing during adulthood is directly or indirectly associated with the conditions or behaviours practiced in their adolescence, for example alcohol and tobacco use, consumption of junk food items, high risk sexual behaviours, physical inactivity, accident proneness, injury and violence, etc., (WHO, 2011). The behaviours that are frequently seen during this developmental phase of adolescence, determine the current health status of the adolescents. They also give an indication of the risks of developing some kind of chronic diseases in the later years of their lives (Adolescent Health Services: Missing Opportunities, 2013).

**Review of Literature:**

According to WHO, the sphere of adolescent health is known as the range of multiple approaches of prevention, detection or treatment of young people's health and their well-being (WHO, 2011). Recent reviews have shown that adolescent health as an area is poorly researched and enough

information on their reproductive and sexual behaviour and their health seeking patterns are serious (Dash, 2006). Adolescent health has received far less attention than it deserves as adolescents are generally perceived as a relatively healthy group. They lack the widespread exposure to infectious diseases as compared to children in their early years. However, among those aged between 0 through 19, the 15-19 year olds experience the next greatest burden of disease after those below age 5 years (Gore et al. 2011). While many enter the adolescent period relatively in a healthy form, but social and physical changes as well as risky behaviours can put the adolescents on a path towards poorer health. The implications of adolescent girls' health have concerns not only for themselves but also for the future generations. It is seen that girls with higher levels of education often make better sexual and reproductive health decisions in their life course. Even comprehensive investments in delaying marriage of girls and reducing their childbearing have positive effects on decreasing the population growth. Moreover, increasing the age at first birth also reduces their health risks (Bruce and Bongaarts, 2009). It has been found over a period of time that the girls who are healthier and those with greater education are more likely to have fewer and healthier babies. It is also to be noted that studies have showed that the children born to younger mothers poses comparatively larger risks of mortality before the age of five and of being stunted or underweight at an early age (Temin and Levine 2009).

Research has shown that adolescents are twice as likely to be out of school as children of primary school age. Globally since 2007, the rate of out-of-school adolescents of lower secondary school age continues to hover at almost 18 per cent (i.e. more than 1 out of 6 adolescents). Moreover, girls are more likely to be out-of-school than boys (Statistics, 2015) (UNESCO, Global report on Out-of-School Children, 2016) (UNESCO, Out-of-School Children and Adolescents in Asia and the Pacific, 2015).

Adolescent girls are vulnerable as they tend to stand between adulthood and childhood. More than often, however, their predicaments are largely ignored. It has been observed that a large number of them are married off and become young mothers even before they have the opportunity to realize their full potential. Also if the adolescent girls are not married, the unfortunate removal of them from schools at the onset of puberty often pushes them into taking up household responsibilities (Sinha, 2007). Adolescents face a wide ranging vulnerabilities, ranging from early dropout from school to early marriage, early childbearing and violence (Amin, 2013). The needs and opportunities of both girls and boys diverge during early adolescence, with girls entering puberty on an average of two years earlier than boys. For many adolescent girls in the developing countries, this marks the beginning of a protracted risk period during which they have little or no control over their critical health, social, psycho-social and economic outcomes. It is also seen that sexual maturation, mounting domestic burdens, migration for work, an increasing need for disposable income and pressure for marriage or other sexual relationships, especially

when out-of-school, increases the challenges of adolescence for young girls (Amin, 2013) (Unicef, 2013) (The Adolescent Girls' Vulnerability Index Report, Unicef).

Rural adolescent girls belonging to disadvantaged groups and ST category present the worst scenario in Gross Dropout Rates across the levels of school education. Girl drop out ratio has tended to increase with the enhancement in the level of education. At the primary level, girls dropout rates of 42 per cent is far less than that of 58 per cent at upper primary and a staggering 71.5 per cent in higher classes (IX – X) (Education, 2005). This clearly outlines the pattern of gender inequality in access to education, which seems to be deepening as we move from lower to higher educational attainment and also from urban to rural and to disadvantaged group in the society.

According to a survey among the backward districts in India (Sinha, 2007), a total of 636 cases of dropouts among adolescent girls were reported in comparison to only 78 cases among adolescent boys, across all the districts. The contrasting findings of the survey are given below:

| **Educational Level** | **Number of Dropout Cases** | |
|---|---|---|
| | **Adolescent Boys** | **Adolescent Girls** |
| ***Primary*** | 12 | 108 |
| ***Secondary*** | 53 | 483 |
| ***Above Secondary*** | 13 | 90 |
| ***Total*** | 78 | 636 |

Female literacy rates among the PVTGs in India are also low. This is largely due to lot of factors like the abysmal education infrastructure in the tribal areas, poorly trained or absentee teachers, lack of teaching in tribal languages and irrelevant and alienating curriculum. It is also critical to note the factors that contribute to the decline in population of certain PVTGs, which include malnutrition, diseases like sickle cell anaemia, tuberculosis, cerebral malaria, drug and alcoholic addiction, communicable diseases including veneral diseases, maternal mortality, infant mortality and loss of reproductive ability/ fertility (NAC, 2013).

Adolescence is generally considered as a healthy time of life though several problems either initiate or become peak during these years (Adolescent Health - Healthy People, 2013). Most of these problems are directly or indirectly linked with social determinants and lifestyles operating and interacting in complex environments that precipitate or trigger these conditions or behaviours. When developmental transitions are unprecedented, they often make young people vulnerable, particularly to environmental, contextual or surrounding influences (Mulye TP, 2009). The environmental factors that include family, school, peer-group, neighbourhood, policies and societal cues, can both be supportive or challenging for young people's health and well-being (Adolescent Health - Healthy People, 2013). Reviewing several literature indicated that the young people are mostly prone to a number of health impacting conditions due to their personal choices, the associated environmental influences and lifestyle changes including both

communicable and non-communicable disorders and injuries. Some proneness include substance use disorders (tobacco, alcohol, etc.), Road Traffic Injuries (RTIs), suicides (completed and attempted), Sexually Transmitted Infections (STI) including Human Immunodeficiency Virus (HIV) infection, teen and unplanned pregnancies, homelessness, delinquency, violence and several others (World Youth Report 2003: The Global Situation of Young People, 2004).

High school dropout is a major concern in most developing and underdeveloped countries as it is associated with lower employment rate and poor health conditions (OECD, 2012). Studies have shown that adult health is strongly related to their educational attainment. While prior research has mainly considered poor health a consequence of low education, studies have suggested that, in some cases, the relation can be the result of health selection – poor health causing lower education (Fujiwara T, 2009). Studies also suggested that there is an association between poor health in adolescence and low educational achievement, as self-rated health during adolescence is associated with adult educational level (Huurre T, 2006) (Koivusilta L, 2003). Other studies have indicated that chronic physical conditions or disabilities, mental or psychosomatic symptoms, attention problems, and sleep problems are associated with poor educational attainment (Polderman TJC, 2010). However, there are chances that familial genetics, environmental and socio-economic factors could also influence these kind of associations towards the health of the adolescents (Viner RM, 2012), but yet it is still unclear to what extent the family and other factors can be attributed to the association between health and school dropout (Karin A. A. De Ridder, 2013).

Another study have found out that the common health problems among the rural adolescent girls include under-nutrition and micronutrient deficiencies, sexual and reproductive health problems, menstrual hygiene, overweight and obesity, high risk sexual behaviour, mental disorders, stress, suicide, tobacco use, harmful alcohol use and other substance use disorders, Non-Communicable Diseases (NCDs), domestic violence, sexual and physical abuse, multiple ailments from unhealthy work environments, early or teenage pregnancy, Low-Weight Babies (LWBs), etc. (Welfare, January 2013). Data from Nutrition Survey of National Institute of Nutrition during 2001 and 2006 showed that more than half the population aged between 10-18 years was undernourished (NIN, 2002). Findings have brought out concerning figures related to poor health among adolescents residing in rural areas. For an instance, the prevalence of micro-nutrient deficiencies among girls in rural areas was found to be as high as 25 per cent as reported by Choudhary *et al*. A study of nutritional status of adolescent girls in rural areas of Varanasi (Indian J Prev Soc Med., 2003) found out high prevalence of anaemia more among girls, ranging from 30 to 82 per cent (Wasnik V et al., 2012).

**Rationale:**

A recent joint study by the UNESCO Institute for Statistics and the Global Education Monitoring Report has found that "…47 million adolescents in India have not progressed or not attending

upper secondary school. According to the source, *India has the highest number of Out-of-School children and adolescents in the world.* The report's findings also include that Poverty is a significant barrier to education in India and compulsory education in India is only for 8 years, which is significantly less than the global goal of 12 years*"* (Times of India, 2016).

Female literacy rates among the PVTGs are found to be extremely low, most often much lower than even the State average for the Scheduled Tribe population (Hindu, 2017). Among the 17 states comprising the PVTGs, West Bengal ranks 8$^{th}$ position as per their population size (Census, 2011). But still, it is among the five states which do not have Scheduled Areas. Therefore, it has increased their vulnerability by depriving them from the provisions of protection and rights offered by the Fifth Schedule and the provisions of Panchayat (Extension to Scheduled Areas) 'PESA' Act, 1996 (Xaxa, 2014).

Only 80.1 per cent of adolescent girls in the 15 – 17 years age group attend school. This makes West Bengal only ahead of five states (SRS Survey, 2014). 25.8 percent of women, compared to 15.4 percent men haven't done any kind of schooling in rural West Bengal. The educational attainment among females is most low in the secondary education stage i.e. only 9 per cent of women have completed 10-11years of schooling (ICF, 2017). According to NFHS-4 data, though the school attendance is almost 94 per cent during 6-14 years, but then drops to 70 per cent at ages 15-17 years. This is by far the main reason for selecting the 15-17 years age group for the study. Moreover, the mortal vulnerability of 15+ years is also found high. The per cent of deaths to total deaths during 15–19 years in West Bengal is 1.7 per cent, which is even higher than deaths during 1–4 years (1.4%), 5–9 years (0.6%) and 10–14 years (Sample Registration System Baseline Survey 2014 Report, 2016). If the communicative accessibility to health services institutions is considered, the state is not in an appreciable situation. According to the SRS 2014 Survey, West Bengal among all states ranks at the lowest position in rural connectivity by pucca road (73.4%).

West Bengal, among the bigger states (21 nos.) ranks the lowest in mean age at marriage among females in rural i.e. 18.8 years (SRS Survey, 2014). As per recent findings, the median age at first marriage is found to be exactly 18 years among women aged between 20-49 years and 42 per cent of women aged between 20-24 years are married off before the legal minimum age of 18 (NFHS-4). If the rate of Teenage Pregnancy is viewed among young women (15-19 years) in West Bengal, 18 per cent have already begun child bearing, out of which 2 per cent cases take place to women aging 15 years. It is seen that young women who had no schooling are much more likely to have begun child bearing than young women with 12 or more years of schooling (NFHS-4).

The education system or the school through its safety net mechanisms protects and nurtures the children and adolescents from various risks and vulnerabilities. Since the revision of RMNCH+A operations several programmes for the adolescents like a) Rajiv Gandhi Scheme for Empowerment of Adolescent Girls (RSEAG) or SABLA, b) Scheme for Promotion of Menstrual

Hygiene among Adolescent Girls (10-19 years) in rural India, c) Weekly Iron and Folic Acid Supplementation (WIFS), d) School Health Programme, e) Iron Folic Anaemic (IFA), f) Rashtriya Kishor Swasthya Karyakram (RKSK), g) Rashtriya Bal Swasthya Karyakram (RBSK), h) Kishori Shakti Yojana (KSY), i) Adolescent Education Programme, j) National Nutritional Anaemia Control Programme (NNACP), k) Health Education sessions by service providers, l) Anwesha Counsellor Sessions, etc, and several other programmes and services under National Health Mission (NHM, Rashtriya Madhyamik Shiksha Abhiyan (RMSA) within the school system contributes to comprehensive growth, development and participation of the adolescents. When the girls are out-of-school are then deprived of these protective and rehabilitative services, benefits and thereby stays potentially vulnerable. Once, West Bengal ranked the second state (after Bihar) in having the highest per cent of girls marrying off at the age of 15 years (17.1%) [DLHS-3 Data File], the situation which has improved a lot now after the introduction of the Kanyashree programme for the enrolled adolescent girls (wbgov.in).

There are many reasons why Purulia district is chosen for the proposed study. The literacy rate of the district has been registered at 56.16 per cent and in which the corresponding figures for males and females have been 74.18 per cent and 37.15 per cent. The district ranks 16$^{th}$ position in per capita income (2000-01). Purulia's Health Index was measured as 0.61, Educational Attainment Index as 0.55 and Income Index as 0.18, and thereby in HDI-the district has managed to get 16$^{th}$ position (Census 2011). All the blocks of Purulia district fall into the category of Educationally Backward Blocks (EBBs); female literacy rate of the district is very low; according to the West Bengal Human Developmental Report 2004, the Human Development Index (HDI) for the selected district is poor and is ranked at the 16th position (West Bengal: Development and Planning Department, 2004); and the district has a higher proportion of tribal population (18.45 percent) as per Census 2011 (Sarkar, 2017). Compared to Primary and above-Secondary levels in Purulia, it is seen that girls dropout most during the Secondary level. The average school dropout age among the adolescent girls in Purulia is 14.8 years and household works and distance of school from residence stands as the major reasons for the same and them missing school. However, the average age at marriage is 17 years, 16 years being lowest reported (Sinha, 2007).

All the findings of deprivations and vulnerabilities cited above are directly or indirectly affecting the health situation of the adolescent girls. It hence appears significant to study the health situation of the Out-of-School adolescent girls belonging to PVTG category.

**Aim of the Study:**

The adolescent girls, being already vulnerable due to socio-structural reasons, are more prone to multi-level vulnerabilities if not attending school and belonging to PVTG category. The vulnerabilities can have different dimensions such as economic, psychological, educational, health, etc. There have been debates on how educational attainment helps in managing the health situation of the adolescent girls (Amin, 2013). Therefore, in order to find out how education

improves the health situation of the adolescent girls under PVTGs and reduce some level of vulnerabilities is the main aim of this research study.

**Research Objectives:**

i. To estimate the adolescent girls under PVTGs being Out-of-School and study the factors affecting the enrolment/ continuity of the adolescent girls in schools.

ii. To study in detail those factors which are responsible for educational deprivation and affecting the health situation of adolescent girls under PVTGs.

iii. To understand the health situation of the Out-of-School adolescent girls under PVTGs and explore their access to the health/ adolescent health programmes.

iv. To suggest measures so that the policies related to education and health can improve the health situation of the adolescent girls belonging to PVTG category.

**Research Questions:**

i) What are the reasons for which adolescent girls under PVTGs becoming out-of-school and the cause & effect relationship of them belonging to a PVTG area?

ii) If the Out-of-School adolescent girls under PVTGs vulnerable to health risks, what are the diseases or occurrences of their health problems?

iii) What are the linkages between health situation and not attending/ attending school by the adolescent girls under PVTGs?

iv) What are the scopes for improvement in the policies (education and health) to comprehensively improve the health situation of the studied adolescent girls?

**Methodology:**

***Research Design:***

In order to address the proposed research objectives, both qualitative and quantitative data will be required. The mixed-method research design will largely be adopted in this context.

***Universe of the Study:***

The PVTGs of West Bengal include Toto, Lodha and Birhor. The demographic features for PVTGs in West Bengal are as cited below:

| PTG | Population | | | Literacy Status | | | Literacy % | | |
|---|---|---|---|---|---|---|---|---|---|
| | Male | Female | Total | Male | Female | Total | M | F | T |
| ***Toto*** | 749 | 642 | 1391 | 585 | 477 | 1062 | 78.1 | 74.3 | 76.3 |
| ***Lodha*** | 30,537 | 29,599 | 60,136 | 11909 | 7696 | 19605 | 38.9 | 26 | 32.6 |
| ***Birhor*** | 163 | 170 | 333 | 39 | 24 | 63 | 23.9 | 14.11 | 18.9 |

Source: www. http://adibasikalyan.gov.in

The disadvantaged adolescent population (U-DISE, 2015) of Particularly Vulnerable Tribal Groups (PVTGs) i.e the Lodhas and Birhors in Purulia district (http://tribal.nic.in) of West

Bengal will be the universe of the proposed study. The updated total number of the target population will be collected from the Office of the Backward Classes Welfare or SC/ST Cell, District Headquarters. Furthermore, the total number of the adolescent girls among the target communities will be collected from the District RKSK/RBSK (Rashtriya Kishor Swasthya Karyakram/Rashtriya Bal Swasthya Karyakram) Cell & RMSA department. Demographic details & other inputs will be collected from SI office and the agencies of the SABLA if available.

***Sample Design of the Study:***

As per the Census 2011 data, the population of adolescent girls (15-17 years) of Lodha and Birhor communities separately in Purulia isn't available currently. Only the ST population (18.45%) and total population of Lodhas (1,08,707) and Birhors (2,241) in West Bengal is available . So, estimating the exact sample size for the study is not being possible now. The researcher will visit the district and explore the field to find out the exact population of the target population, the number of blocks (among total 20 nos.) having their prevalent population, before calculating the sample size and sampling techniques thereafter.

***Methods of Data Collection:***

For primary data collection, following methods will be adopted:

- *Qualitative Data* – Case studies (4 from Birhor, 4 from Lodha respondents) and Focussed Group Discussions;
- *Quantitative Data* – Semi-structured Interviews.

| | | |
|---|---|---|
| **Objective 1:** | Nature of Data Required | Primary Data |
| | Tools of Data Collection | Semi-structured Interviews, FGDs |
| | Indicators | OOS adolescent girls, 15-17 years, Lodha and Birhor Community, Tribal villages of Purulia district |
| | Sources of Data | RKSK Cell, Schools, PRI depts., Respondents |
| **Objective 2:** | Nature of Data Required | Secondary and Primary data |
| | Tools of Data Collection | Literature Review, Semi-structured interviews, FGDs |
| | Indicators | School attendance, Health programmes and services in secondary schools |
| | Sources of Data | Schools, RKSK cell, Health depts., CMOH office |
| **Objective 3:** | Nature of Data Required | Primary Data |
| | Tools of Data Collection | Semi-structured Interviews, FGDs |
| | Indicators | Social, Physical and Mental health seeking behaviour |
| | Sources of Data | Respondents |
| **Objective 4:** | Nature of Data Required | Primary Data |
| | Tools of Data Collection | FGDs, Semi-structured Interviews, Observation |
| | Indicators | Implementation of education and health related services |
| | Sources of Data | Schools, Respondents, Health service providers |

Firstly, the available literature related to the research problem will be reviewed in order to find out the research gaps from the relevant studies. For this purpose, most of the literature published

from 2006 onwards will be collected from various sources. Being the study depending upon both primary and secondary data, the secondary data will be collected from different available literature and web resources including books, journals, newspapers, government and others reports, previous studies conducted on related field of proposed research, websites, virtual library, archives, etc. The primary sources of data will mostly depend on the information to be given by the respondents of the study. Apart from that, the researcher has considered the methods of photography, videography and observation in the field of study as important sources of primary data.

***Data Inclusion Criterion:***

- Out-of-School Adolescent Girls (School Attendance)
- PVTG (Lodha, Birhors)
- Area (Rural areas of Purulia district)
- Age (15 – 17 years)

**Operational Definitions:**

***Health Situation (Adolescent Health Situation)* –** Adolescent health is a construct of both biological and non-biological factors. The health of an adolescent is a confluence of variety of influencing factors. Ranging from the *social factors* such as early marriage, early pregnancy, declining sex ratio, domestic violence and sexual abuse, lower school enrolment and higher school drop-out rates, etc., to multiple layers of influence on the *adolescent environment,* which comprises of communities, schools, workplaces and peers. However, the following influencing factors will be taken into consideration while assessing adolescent health (RKSK Operational Framework, 2014):

- **Social Health**
  *Indicators:* Early Marriage, Access to health services, Gender discrimination.
- **Physical Health**
- *Indicators:* Mal-nutrition and Iron Deficiency Anaemia – IDA, Knowledge, attitudes and behaviour in relation to Sexual and Reproductive Health; Teenage Pregnancy; Substance Misuse; Gender based Violence.
- **Mental Health:**
  *Indicators:* Depression/ Stress, Aggression, Anxiety.

***Out-of-School (OOS)*** – When an adolescent is identified as 'out-of-school', it encompasses a wide range of educational deprivations and refers to the adolescents who are (UNICEF, 2015):

a. *Not Enrolled: i)* Do not have access to a school in their community (which according to RMSA, secondary school within 5 kms radius and higher secondary school within 7-10 kms); and ii) Did not enrol despite availability of a school.

b. *Dropping Out: i)* Dropped out from formal education system; and ii) Has enrolled but not attend school.

***Adolescents* –** Coinciding with the varied definitions of adolescents across national and global policies, the proposed study perceives the 15 – 19 years age group ideally as adolescents. However, for operational purposes, 15 – 17 years (Class XI to X/ XI) adolescent girls will be considered for the study.

***Particularly Vulnerable Tribal Group* –** The features of a PVTG are: a pre-subsistence level economy, i.e., practice of hunting and gathering, stagnant or decreasing population growth, extremely low level of literacy in comparison to other tribal groups. The tribes that satisfied any one of the criterion were considered as PVTGs, essentially with recommendations from the respective State Governments. In West Bengal 3 tribal groups fulfilled the criteria, out of which 2 (Lodha and Birhor) resides in Purulia district.

**Theoretical Framework:**

By studying the health situation of the Out-of-School adolescents, the researcher will only have to assess the respondents' transactions in their environment, and thereby will be adopting the lenses of Ecological Perspectives. This will be helpful for theorizing the reciprocal interactions that occur between the systems (individual, family, group systems, surrounding larger social system) and the resulting effects. It will further broaden the vision for understanding and interpreting the person-in-environment perspective (Franklin, 2014). The study will also be documented through the lenses of Bronfenbrenner's Ecological Framework for Human Development (1979), in which the development of a person involves individuals themselves, their environment and interactions between the two. Using this framework, the researcher will measure the health situation at three different levels – i) the individual, ii) household and iii) community level. The health related risk factors concerning adolescent girls are present at multiple levels from the individual level to familial, institutional and community levels. A girl's health will be defined as most vulnerable if she experiences risks factors at all of these levels.

While conceptualizing health situation, this study will be using an ecological model to show how community, household and individual factors affect adolescent girls' well-being of those who are out-of-school. For an example, for determining the health of a 15 year old girl, it can include interactions between the girl and school but also the interactions between the school and her family.

i) **Individual level –** Schooling (*Educational attainment, School enrolment/ attendance, Literacy),* Sexual and Reproductive Health *(Sexual and health seeking behaviour, Knowledge of prevention and health and hygiene),* Family formation *(Age at marriage)* -

Girls' attendance in formal schooling is associated with delayed sexual initiation, marriage and child bearing; lower rates of HIV/AIDS; and engaging in fewer hours of domestic work. Improvements in schooling lead to improved health of women and their families. Higher maternal education is associated with safer health and hygiene practices, greater access to information used to enhance children's health, better nutrition and more equality in household relationships (Lloyd and Young 2009).

ii) **Household level –** Access to improved sanitation and water source, Diet and nutrition, and Household head and members with no education.

iii) **Community level –** Emphasizing on the social climate of the community where the adolescent girl lives in, with prevalence of – Child/ Early Marriage, Illiteracy, Low comprehensive knowledge on HIV and SRH (Sexual and Reproductive Health). In communities where these practices are more prevalent, girls are more likely to be socially isolated and have less control over their health and future (Amin, 2013).

To support the data interpretation, the Bristol Approach will be necessarily referred to – Access to basic services, education, food, health, information, sanitation, shelter, water are some of its indices (Amin, 2013).

**Tentative Chapterization Plan:**

CHAPTER 1: Introduction
CHAPTER 2: Review of literature
CHAPTER 3: Methodology
CHAPTER 4: Profile of Respondents (background at a glance)
CHAPTER 5: Health Situation of OOS Adolescent Girls under Study
CHAPTER 6: Discussions and Conclusions
References and Bibliography
Annexure

**Tentative Time Frame:**

*Stage One:* Research Training, Literature Review - one year will be required.

*Stage Two:* Developing and Piloting of tools to be used, Continuing Literature review, and Gathering Secondary data. One year will be required to assemble the activities.

*Stage Three:* Primary data collection and supplementation of literature review will involve around 6 to 8 months.

*Stage Four:* Analysis of data and Report writing tasks may require another one year.

**Tentative Time Frame Matrix:**

| Year | Months | Research Training | Literature Review | Gathering Secondary Data | Developing Tools | Conducting Pilot Study | Primary Data Collection | Data Analysis | Report Writing |
|---|---|---|---|---|---|---|---|---|---|
| **Yr 1** | **6 months** | √ | √ | √ | | | | | |
| | **6 months** | | √ | √ | | | | | |
| **Yr 2** | **6 months** | | √ | √ | √ | √ | | | |
| | **6 months** | | | | √ | | | | |
| **Yr 3** | **6 months** | | √ | √ | √ | | √ | | |
| | **6 months** | | | | | | √ | √ | |
| **Yr 4** | **6 months** | | √ | √ | | | √ | √ | √ |
| | **6 months** | | √ | √ | | | √ | √ | √ |

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